Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909
517-335-0918
Fax 517-373-2179
WWW.MICHIGAN.GOV/HEALTHLICENSE

Board Use Only

DATA CHANGE/DUPLICATE LICENSE REQUEST

Authority: Public Act 368 of 1978, as amended.

PHARMACY STORES AND MANUFACTURER/WHOLESALER/DISTRIBUTORS MAY NOT USE THIS FORM FOR A NAME OR ADDRESS CHANGE. YOU WILL NEED TO COMPLETE A RELOCATION APPLICATION WHICH CAN BE OBTAINED EITHER ONLINE AT WWW.MICHIGAN.GOV/HEALTHLICENSE OR BY CONTACTING OUR OFFICE.

Type or Print Only

Current Name on License/Registration: _____
Last First Middle

Please state profession(s) you are requesting to be changed:

Profession: _____

MI Permanent I.D. Number: _____

Date of Birth	Phone Number	U. S. Social Security Number

Please specify which licenses/registrations you want changed. **NO CHANGES WILL BE MADE IF THIS FORM IS NOT COMPLETE.**

❒ Professional License/Registration ❒ Specialty License ❒ Controlled Substance ❒ Drug Control

Please check the boxes below for the service you are requesting:

❒ 1. **NAME CHANGE**: I request the Department to change my records due to a name change. Signature must be provided on reverse side. If you would like a new license reflecting your new name, please see fee requirement on reverse side.

New Name:
(Print Clearly) _____
Last First Middle

Reason for Change: _____

❒ 2. **ADDRESS CHANGE: FOR PROFESSIONAL AND/OR SPECIALTY.** I request the Department to change my record due to an address change.

Name of Facility or Office: _____

Address: _____

City, State and Zip Code: _____

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name:

❒ 3. **ADDRESS CHANGE: FOR CONTROLLED SUBSTANCE AND DRUG CONTROL LICENSE**

MI Permanent I.D. Number: _____

I am requesting that the Department change my records due to an address change. If additional controlled substance licenses need changing, please send a request for each one.

Name of Facility or Office: _____

Address: _____

City, State and Zip Code: _____

Phone Number: _____

4. **DUPLICATE LICENSE $10.00 per license**: I am asking the Department to issue a duplicate for the following reason:

❒ Data Change (Complete Front Side) ❒ Lost ❒ Stolen ❒ Not received ❒ Destroyed

I need a duplicate of the following license(s). Make your check payable for the total amount.

❒ Professional License/Registration - $10.00 ❒ Specialty License - $10.00

❒ Drug Control - $10.00 ❒ Controlled Substance - $10.00

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

You will not receive notification of the change(s). You can check our web site after two weeks to confirm the change by selecting the "verify a license" link at http://www.michigan.gov/verifylicense.

Signature:	Date: